Elementary Family Questionnaire

Your responses on this questionnaire will help us to learn more about your child. Please complete each item and return it with your completed application form. There are no “right” or “wrong” answers to the questions.

Child’s name: ____________________________ Birthdate: ______________ M F

1st Parent name: ___________________________ 2nd Parent name: ___________________________

Email: ___________________________ phone #: ___________________________

What languages are spoken in the home? ___________________________

**General:** *Tell us about your experiences with and observations of your child:*

1. Describe a typical weekday for your child.

2. Describe a typical weekend for your child.

3. What are two things that your child likes to do best?

4. What are two things that your child does not like to do?
Elementary Family Questionnaire

5. What is your favorite thing to do with your child?

6. What are three words you feel best describe your child?

7. What do you enjoy most about your child? What makes your child special?

8. Does your child have siblings? If yes, what ages?

9. What school does your child attend?

10. Has your child ever been sent home from school for their behavior? Please explain.

11. What educational goals do you have for your child? (social, math, language, science, cultural studies)
11. How do you see CMS facilitating these goals?

12. How would you describe your child’s personality and learning style?

13. What do you see as your child’s greatest strengths?

14. In what areas would you like to see your child’s potential more fully developed?

**Practical Life at Home:** *Tell us about your child’s routines and general skills*

1. What is your child’s normal bedtime? Where do they usually fall asleep?

2. What time does your child normally wake up in the morning?

3. What does your child normally eat for breakfast?

4. What does your child like to eat most?

5. Are there any foods that they will not eat?

6. Please tell us about your approach to discipline.
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Medical History

1. Were there any significant problems during pregnancy or directly following birth that might have an effect on your child’s development (i.e. premature birth, low birth weight, etc.)

2. Was your child more than 3 weeks premature?

3. Have you ever suspected your child has vision problems? If yes, please explain.

3. Have you ever suspected that your child has hearing problems? If yes, please explain

4. Has your child ever had trouble walking, climbing, reaching or holding on to things? If yes, please explain.

4. Does your child have allergies? If yes, please explain.

5. Is your child presently on any medications? If yes, please explain.

Can your child:  

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<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<td>Express their thoughts and needs easily?</td>
<td></td>
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<td>Use the restroom independently during the day?</td>
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Does your child: Please circle your answer

- Use crayons and/or makers to scribble or draw? YES NO
- Listen to stories being read? YES NO
- Recall stories or events? YES NO
- Talk with friends/relatives who come to visit? YES NO
- Follow simple, age-appropriate directions? YES NO
- Have opportunities to play with other children? YES NO

Is there any other information regarding your child’s development that you would like to share with us?

Signature of Parent/Guardian ______________________________ Date ________________

How did you hear about Children’s House Montessori School?

CMS Alumni or current Family ______________________________

Google or other search Press Advertisement Social Media

What is your experience with Montessori education?